



## Promoting normality in the management of the perineum during the second stage of labour

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# **The midwife's role in promoting normality in the management of the perineum during the second stage of labour**

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## **Abstract**

The management of the perineum during birth has multiple long term effects on women and their families. The midwife has a key role to play and often midwives vary significantly in the techniques they employ and their justification of these practices. This article seeks to examine current evidence to explore what is known to contribute to lower perineal trauma rates and what practices should be avoided to protect childbearing women. The conclusions drawn may require the updating of practice as well as antenatal education so that woman should be given the information they need to make an informed choice as to what they want for their own body, child and experience.

## **Key Phrases**

The entire focus of midwifery practice is woman-centred care.

The midwife as an advocate, involves protecting women from unnecessary intervention which may lead to negative birth experiences.

Removing pain and factors which interrupt a woman's natural enjoyment of the early postnatal period is vital for the promotion of bonding and breastfeeding and thus overall improved women and child health.

Antenatal perineal massage should be advocated by midwives during antenatal care in order to promote women's involvement in their own care and enable them to have a measure of control over what takes place in the second stage of labour.

## **The midwife's role in promoting normality in the management of the perineum during the second stage of labour**

### **Introduction**

The pain experienced by women during childbirth is often reported as most severe during the second stage of labour. Many women fear this pain and doubt their ability both to cope and to deliver their baby vaginally. The necessity of effective support provided by the midwife throughout labour and particularly in second stage is well documented (Hodnett et al. 2012) but there remains a wide variation of practices by midwives to reduce pain and to prevent severe perineal trauma (Sanders et al. 2005). The issue of the midwife's role in the management of the second stage of labour is often controversial and practices inconsistent from one midwife to another yet the outcome directly affects a woman's childbirth experience. This article aims to address the midwife's role in promoting normality relative to the management of the perineum during second stage of labour. The factors influencing this topic are consistent with general issues faced by practising midwives, stemming from women's desires and choice, the advantages and contraindications of various practices, the suggestions and boundaries of guidelines and policies and ultimately, recent and reliable evidence. The 'normal' is very difficult to define yet promotion of normality in childbirth is frequently identified as a major aspect of the midwife's role (International Confederation of Midwives (ICM) 2005; Nursing and Midwifery Council (NMC) 2004). It is argued that the promotion of normality is based mainly on preventing the need for intervention

(Maternity Care Working Party (MCWP) 2007) whilst the midwife as an advocate involves protecting women from unnecessary intervention which may lead to negative birth experiences. Midwifery care must be designed and tailored for each woman, recognising the potential devastating effects a negative birth experience can have on a woman's self-esteem, her transition to motherhood and the subsequent impact on the newly-formed family (Lawrence-Beech and Phipps 2008). Riddick-Thomas (2009), suggests the midwife has a professional duty firstly to herself, to the woman in her care, the woman's baby and family, the midwife's colleagues, employer, the midwifery profession and to the NMC. It is the midwife's professional responsibility to provide care based on the latest, most reliable evidence (NMC 2008) and to continue lifelong learning (Macdonald 2011) by drawing on the experiences of self as well as colleagues, relying on current education, and developing evidence as midwifery advances (Fraser and Cooper 2009).

#### Why focus on perineal management?

The potential short and long term effects of perineal trauma during childbirth create multiple problems for women, so effective management of the perineum must be a priority for midwives (Albers 2006). The wellbeing of a newborn depends upon its mother's ability to function (Albers and Borders 2007). Women want to return to their familiar, normal selves and a painful perineum influences the ability to do this (Way 2012). Pain becomes a distraction, preventing the woman's completion of basic daily functions and interfering with independent care of the baby, thus affecting self-

confidence as a mother (Way 2012). Other morbidities include difficulties in mobilisation, finding comfortable positions for breastfeeding (Soong and Barnes 2005) and dyspareunia which can potentially have a tremendous impact on relationships and bonding (Andrews et al. 2008). Particularly where severe trauma is sustained, women suffer significant emotional distress at an already emotionally complex and demanding time (Williams et al. 2005). Removing pain and factors which interrupt a woman's natural enjoyment of the early postnatal period is vital for the promotion of bonding and breastfeeding and thus overall improved women and child health.

#### What techniques are proven to improve outcome?

A literature review surrounding antenatal perineal massage shows that women who perform perineal massage are at lower risk of perineal trauma mainly because their risk of episiotomy is reduced (Beckmann and Garrett 2009). Women who performed perineal massage also reported reduced pain in the postnatal period regardless of episiotomy. The authors note that all studies included are of reliable quality. The outcome of the review is that antenatal perineal massage should be advocated by midwives during antenatal care in order to promote women's involvement in their own care and enable them to have a measure of control over what takes place in the second stage of labour. Perhaps it is necessary for antenatal education leaders to incorporate perineal massage advice into antenatal care to ensure equality of information and benefit to all women regardless of their ability to access further information alone. Effective antenatal education should ensure that women are proactive in maintaining

normality and control of their own labour, although the evidence around antenatal education and the subsequent benefit on labour and birth is inconclusive (Ferguson et al. 2013).

Instrumental deliveries significantly increase the risk of severe (third or fourth-degree) tears (Albers and Borders 2007) therefore the first prevention of severe trauma is to grasp every opportunity available to encourage normality and increase the chance of normal vaginal deliveries. Methods of reducing instrumental delivery include avoiding epidural analgesia (Anim-Somuah et al. 2011), effective support of the woman (Hodnett et al. 2012) and an environment conducive to labour (Lavender and Kingdon 2006).

The labour environment should aim to reduce stress and accommodate and encourage oxytocin release to ensure progression of labour and the woman's control of labour.

Sidebotham (2012) suggests a valuable list of influences on normal labour including environment, empowering the woman, previous educational exposure to normality, evidence and carers during childbirth. The midwife must always remember the potential impact her attitude and care for the woman will have upon the birth outcome (Lawrence-Beech and Phipps 2008). The midwife must remain the woman's advocate throughout childbirth (NMC 2008); particularly relevant when medical staff are involved with instrumental deliveries. Perhaps, at times, midwives involve medical staff prematurely without first exhausting every technique to encourage normality in labour.

The most effective technique used by midwives to reduce perineal trauma appears to be the use of warm compresses during the active phase of second stage of labour. In a



study in New Mexico which included women from varying ethnic origins, no significant difference in the rate of intact perineum was noted with or without the use of warm compresses (Albers et al. 2005). This was a large trial (n=1211) and midwives compliance with the research technique was good. However, the unit completing this study had a significantly lower rate of perineal trauma than other units; therefore the generalisability of the results is limited. In an Australian study of warm compresses including 717 women, results showed significant reduction of pain in the final stage of labour, severe tears, pain in the first 2 days post-delivery and urinary incontinence at three months postnatal (Dahlen 2007b). One limitation of this trial is the high rate of third and fourth degree tears in both groups but almost one third of women included were of Asian descent, a factor known to predispose women to severe perineal tears (Dahlen 2008). A Cochrane review of the literature surrounding management of perineal trauma confirms the benefit of warm compresses during second stage (Aasheim et al. 2012). This method is available at every birth, non-invasive, inexpensive, causes no harm and women find it comfortable.

A controversial technique employed by midwives is hands on the perineum versus hands poised. The seminal HOOP trial (McCandlish et al. 1998), reports that women felt significantly more perineal pain at 10 days post-delivery when midwives used the hands poised method. However, the hands poised method was not hands off and is described as the midwife applying her hand 'lightly' to the advancing vertex. It is difficult to compare this pressure and therefore this inconsistency may affect results.

Soong and Barnes (2005), report that women giving birth in the semi-recumbent position are much more likely to sustain perineal trauma than in upright positions. Although a relatively large study, the unbalanced group sizes excludes statistical reliability of differences between perineal outcomes and position at delivery. A recent Cochrane review of positions of women without epidural in second stage of labour showed that women in upright positions reduced the likelihood of episiotomy compared with supine positions. However, in the upright positions there was a slight increase in the incidence of second degree tears (Gupta et al. 2012). Another older study concludes that the lateral position is the optimal position for an intact perineum with squatting being the least favourable (Shorten et al. 2002). Some of the included women were cared for by obstetric staff rather than midwives and this is known to reduce the intact perineum rate (Browne et al. 2010). NICE (2007) suggest that women should be advised to seek the most comfortable position and the midwife must facilitate this. Women should be advised of any increased risks of the position chosen. Woman's choice is widely reported as a vital factor in improving women's satisfaction of birth experience regardless of outcome.

Delivery of the fetal head between contractions is preferable, requiring patience and effective communication between midwife and woman. A calm, unhurried delivery is more satisfying for women and reducing perineal trauma results in less need for suturing (Albers et al. 2006). Women can maintain control and minimise active pushing by gentle blowing or sighing (Charles 2009). Smooth birth of the shoulders may reduce

perineal lacerations (Charles 2009; Downe 2009). The conclusions of the Cochrane review of management of the perineum suggest further research is required regarding breathing technique to control the speed and force of delivery and perhaps there is more benefit from this technique than all the hands on managements (Aashiem et al. 2012). The Valsalva manoeuvre is already contraindicated by fetal wellbeing and Albers et al. (2006) report that this increases the risk of perineal trauma.

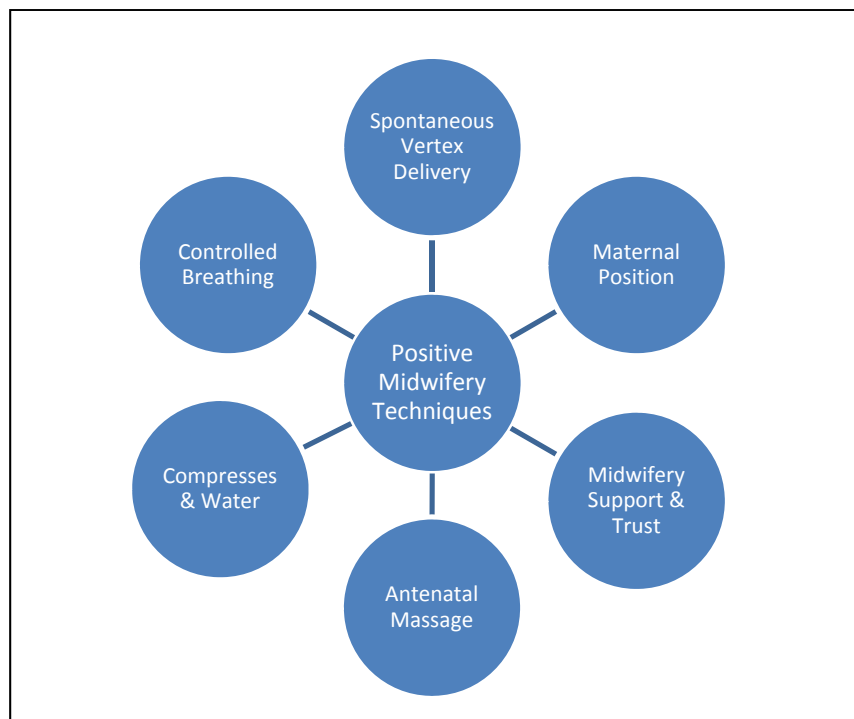
A Cochrane Review of the immersion of women in water in both first and second stage of labour found no significant difference in perineal trauma between those who birthed in or out of water (Cluett and Burns 2009). A more recent study not included in the review, included 3950 women and reports that water birth significantly reduces perineal morbidity compared with various positions on land (Dahlen et al 2012). A further study of 438 women concludes that water must have a protective factor for the perineum due to significantly higher rate of intact perineum and fewer severe perineal lacerations in water than on land (Menakaya et al. 2012). Although not mentioned in literature, women of increased risk and not eligible for waterbirth, may find relief from soaking of the perineum with warm or cool water during second stage. Again, this method is simple to provide and is not known to cause harm.

A small Brazilian study (Scarabotto and Riesco 2008) considered the use of hyaluronidase injections into the perineum during second stage and found that the incidence and severity of perineal trauma was significantly reduced in the intervention group. This method would need to be researched on a sample, both larger in number

and suitable to apply results to the UK before practice could be adapted. Further research is required to ensure hyaluronidase injections would be beneficial to women perhaps at increased risk of severe trauma rather than offering all women “prophylactic” treatment.

Finding methods of preventing genital tract trauma would be beneficial to a large number of women and simplify postnatal care in terms of reducing the need for suturing, analgesic drugs and follow-up appointments by obstetric staff (Albers et al. 2005). In times of economic difficulty, this could make significant differences to maternity budgets as well as the obvious benefits to women and their families.

Although beyond the scope of this article, contributing factors to breastfeeding success must be considered in view of health and psychological benefits to woman and baby in the long-term and if any reduction in perineal trauma benefits breastfeeding rates, is this not reason enough to challenge the episiotomy-friendly practice that persists despite clear evidence confirming the opposite?



**Diagram 1: Positive midwifery techniques to reduce perineal trauma**

Although controversial, general guidance is that episiotomy should only be performed for fetal reasons including fetal distress, lack of progress of second stage because of failure of the perineum to distend, and to protect the fetus from damage in cases of breech, face or instrumental deliveries (Gibbon 2012). Sufficient time should be given to allow the perineum to stretch slowly and perhaps this time is not always facilitated in labour wards today. The normal expectation is that the perineum will be capable of stretching and faith in the woman's body should prevail until deviation from the normal is evident. Routine infiltration of the perineum with anaesthesia is not recommended in the absence of any research into associated benefits or harm. It is suggested that the

additional volume in the perineum may affect tissue elasticity and increase the risk of spontaneous trauma (Saunders et al. 2005).

## Conclusion

The practice points to be taken from this article mainly focus on the need for antenatal education and women's involvement in their own birth plans as well as the positions used in second stage, the use of warm compresses and the position of the midwife's hands. In conclusion, the entire focus of midwifery practice is woman-centred care. It is the woman who, having the required information at an appropriate stage of pregnancy to make an informed decision, can decide whether she permits a midwife to touch her perineum or her baby's emerging head. Promoting normality must include instilling faith in the woman to trust in her body to complete its amazing physiological work and also the belief of the midwife to allow birth to progress. Lawrence-Beech and Phipps (2008) suggest that many women remember their birth experience until they die. It is the aim of the midwife that the woman reflects with joy and positivity the beginning of motherhood. The midwife's accountability to childbearing women and the following generations reaches beyond any regulatory body (Lawrence-Beech and Phipps 2008) because her attitude and practice and the woman's perception of her experience has the potential to change the lives of the woman, her partner, her baby and the wider family and social network. To be a midwife, is to truly be "with woman", providing safe care, centred completely upon that woman so that her childbearing experience

empowers her for the first weeks and subsequent years of the baby's life (Page and McCandlish 2006).

### Reference List

Aasheim, V., Nilsen, A., Lukasse, M. and Reinar, L. (2011) 'Perineal techniques during the second stage of labour for reducing perineal trauma', *Cochrane Database of Systematic Reviews*, 2, Wiley [Online]. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006672.pub2> (Accessed: 1 November 2012).

Albers, L., Sedler, K., Bedrick, E., Teaf, D. and Peralta, P. (2005) 'Midwifery care measures in the second stage of labor and reduction of genital tract trauma at birth: a randomized trial', *Journal of Midwifery and Women's Health*, 50 (5), pp. 365-372.

Albers, L., Sedler, K., Bedrick, E., Teaf, D. and Peralta, P. (2006) 'Factors related to genital tract trauma in normal spontaneous vaginal births', *Birth*, 33 (2), pp. 94-100.

Albers, L. and Borders, N. (2007) 'Minimizing genital tract trauma and related pain following spontaneous vaginal birth', *Journal of Midwifery and Women's Health*, 52 (3), pp. 246-253.

Andrews, V., Thakar, R., Sultan, A.H. and Jones, P. (2008) 'Evaluation of postpartum perineal pain and dyspareunia – A prospective study', *European Journal of Obstetrics, Gynecology and Reproductive Biology*, 137 (2), pp. 152-156.

Anim-Somuah, M., Smyth, R. and Jones, L. (2011) 'Epidural versus non-epidural or no analgesia in labor', *Cochrane Database of Systematic Reviews*, 12, Wiley [Online]. Available at:

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000331.pub3> (Accessed: 7 December 2012).

Beckmann, M. and Garrett, A. (2009) 'Antenatal perineal massage for reducing perineal trauma', *Cochrane Database of Systematic Reviews*, 1, Wiley [Online]. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005123.pub2> (Accessed: 15 November 2012).

Browne, M., Jacobs, M., Lahiff, M. and Miller, S. (2010) 'Perineal injury in nulliparous women giving birth at a community hospital: reduced risk in births attended by certified nurse-midwives', *Journal of Midwifery and Women's Health*, 55 (3), pp. 243-249.

Byrd, L., Hobbiss, J. and Tasker, M. (2005) 'Is it possible to predict or prevent third degree tears?', *Colorectal Disease*, 7 (4), pp. 311-318.

Charles, C. (2009) 'Labour and normal birth', in Chapman, V. and Charles, C. (eds.) *The Midwife's Labour and Birth Handbook*. 2<sup>nd</sup> edn. Chichester: Wiley-Blackwell, pp. 1-31.

Cluett, E. and Burns, E. (2009) 'Immersion in water in labour and birth', *Cochrane Database of Systematic Reviews*, 2, Wiley [Online]. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000111.pub3> (Accessed: 15 November 2012).

Dahlen, H., Ryan, M., Homer, C. and Cooke, M. (2007a) 'An Australian prospective cohort study of risk factors for severe perineal trauma during childbirth', *Midwifery*, 23 (2), pp. 196-203.

Dahlen, H., Homer, C., Cooke, M., Upton, A., Nunn, R. and Brodrick, B. (2007b) 'Perineal outcomes and maternal comfort: perineal warm packs in second stage', *Birth*, 34 (4), pp. 282-290.



Dahlen, H., Dowling, H., Tracy, M., Schmied, V. and Tracy, S. (2012) 'Maternal and perinatal outcomes amongst low risk women giving birth in water compare to six birth positions on land. A descriptive cross sectional study in a birth centre over 12 years', *Midwifery, ScienceDirect* [Online]. Available at: <http://dx.doi.org/10.1016/j.midw.2012.07.002> (Accessed: 20 November 2012).

Downe, S. (2009) 'The transition and the second stage of labour: physiology and the role of the midwife', in Fraser, D. and Cooper, M. (eds.) *Myles Textbook for Midwives*, 15<sup>th</sup> edn. Edinburgh: Churchill Livingstone, pp. 509-530.

Ferguson, S., Davis, D. and Browne, J. (2013) 'Does antenatal education affect labour and birth? A structured review of the literature', *Women and Birth*, 26 (1), pp. e5-e8.

Fraser, D. and Cooper, M. (2009) 'The midwife', in Fraser, D. and Cooper, M. (eds.) *Myles Textbook for Midwives*, 15<sup>th</sup> edn. Edinburgh: Churchill Livingstone, pp. 3-10.

Gibbon, K. (2012) 'How to perform an episiotomy', *Midwives*, Issue 5, pp. 34-35.

Hodnett, E., Gates, S., Hofmeyr, G. and Sakala, C. (2012) 'Continuous support for women during first stage labour', *Cochrane Database of Systematic Reviews*, 10, Wiley [Online]. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003766.pub4> (Accessed: 7 December 2012).

International Confederation of Midwives (2005) *Definition of the Midwife*. Available at: <http://www.internationalmidwives.org/Portals/5/Documentation/ICM%20Definition%20of%20the%20Midwife%202005.pdf> (Accessed: 7 December 2012).

Lavender, T. and Kingdon, C. (2006) 'Keeping birth normal', in Page, L. and McCandlish, R. (eds.) *New Midwifery*. 2<sup>nd</sup> edn. Philadelphia: Churchill Livingstone, pp. 333-358.

Lawrence-Beech, B. and Phipps, B. (2008) 'Normal birth: women's stories', in Downe, S. (ed.) *Normal Childbirth Evidence and Debate*, 2<sup>nd</sup> edn. Edinburgh: Churchill Livingstone, pp. 67-80.

Macdonald, S. (2011) 'The midwife as a lifelong learner', in Macdonald, S. and Magill-Cuerden, J. (eds.) *Mayes' Midwifery*. 14<sup>th</sup> edn. Edinburgh: Elsevier, pp. 47-64.

Maternity Care Working Party (2007) *Making Normal Birth a Reality Consensus Statement*. Available at: <http://www.rcog.org.uk/files/rcog-corp/uploaded-files/JointStatementNormalBirth2007.pdf> (Accessed 4 December 2012).

Menakaya, U., Albayati, S., Vella, E., Fenwick, J. and Angstetra, D. (2012) 'A retrospective comparison of water birth and conventional vaginal birth among women deemed to be low risk in a secondary level hospital in Australia', *Women and Birth, Elsevier* [Online]. Available at: <http://dx.doi.org/10.1016/j.wombi.2012.10.002> (Accessed: 20 November 2012).

National Institute for Health and Clinical Excellence (NICE) (2007) *Intrapartum Care*. Available at: <http://www.nice.org.uk/guidance/CG55> (Accessed: 31 October 2012).

NICE (2007) *Intrapartum Care*. Available at: <http://www.nice.org.uk/nicemedia/live/11837/36280/36280> (Accessed: 20 November 2012).

Nursing and Midwifery Council (2008) *The Code*. Available at: <http://www.nmc-uk.org/Nurses-and-midwives/Standards-and-guidance1/The-code/The-code-in-full> (Accessed: 31 October 2012).

Nursing and Midwifery Council (2004) *Midwives Rules and Standards*. Available at: <http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Midwives-rules-and-standards.pdf> (Accessed: 4 December 2012).

Page, L. and McCandlish, R. (2006) 'The new midwifery: science and sensitivity in practice', in Page, L. and McCandlish, R. (eds.) *New Midwifery*. 2<sup>nd</sup> edn. Philadelphia: Churchill Livingstone, pp. xiii – xx.

Riddick-Thomas, N. (2009) 'Ethics in midwifery', in Fraser, D. and Cooper, M. (eds.) *Myles Textbook for Midwives*, 15<sup>th</sup> edn. Edinburgh: Churchill Livingstone, pp. 55-66.

Royal College of Midwives (RCM) (2012) *Evidence based guidelines for midwifery-led care in labour: care of the perineum*. Available at: [www.rcm.org.uk/college/policy-practice/guidelines/practice-guidelines](http://www.rcm.org.uk/college/policy-practice/guidelines/practice-guidelines) (Accessed: 20 November 2012).

Sanders, J., Peters, T. and Campbell, R. (2005) 'Techniques to reduce perineal pain during spontaneous vaginal delivery and perineal suturing: a UK survey of midwifery practice', *Midwifery*, 21 (2), pp. 154-160.

Scarabotto, L. and Riesco, M. (2008) 'Use of Hyaluronidase to prevent perineal trauma during spontaneous deliver: a pilot study', *Journal of Midwifery and Women's Health*, 53 (4), pp. 246-253.

Shorten, A., Donsante, J. and Shorten, B. (2002) 'Birth position, accoucher and perineal outcomes: informing women about choices for vaginal birth', *Birth*, 29 (1), pp. 18-27.

Sidebotham, M. (2012) 'Promoting normal birth the easy way', *The Practising Midwife*, 15 (10), pp. 23-25.

Soong, B. and Barnes, M. (2005) 'Maternal position at midwife-attended birth and perineal trauma: is there an association?', *Birth*, 32 (3), pp. 164-169.

Way, S. (2012) 'A qualitative study exploring women's personal experiences of their perineum after childbirth: expectations, reality and returning to normality', *Midwifery*, 28 (5), pp. e712-e719.

Williams, A. (2005) 'Women's experiences after a third degree obstetric anal sphincter tear: a qualitative study', *Birth*, 32 (2), pp. 129-136.